

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/11/2014
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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F000000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: July 7,8,9,10, &amp; 11, 2014</p> <p>Facility Number: 000216 Provider Number: 155323 AIM Number: 100267580</p> <p>Survey Team: Heather Hite, RN - TC Julie Ferguson RN Jennifer Redlin, RN (July 7, 8, 10, and 11, 2014) Caitlyn Doyle, RN (July 8,9,10, and 11, 2014) Janelyn Kulik, RN (July 7 and 8, 2014) Regina Sanders, RN (July 7 and 10, 2014)</p> <p>Census Bed Type: SNF/NF: 46 Total:46</p> <p>Census Payor Type: Medicare: 5 Medicaid: 37 Other: 4 Total: 46</p> <p>These deficiencies reflect State findings</p>	F000000	<p>Submission of this Plan ofCorrection does not constitute an admission to or an agreement with factsalleged on the survey report.</p> <p>Submission of this Plan ofCorrection does not constitute an admission or an agreement by the provider ofthe truth of facts alleged or corrections set forth on the statement ofdeficiencies.</p> <p>The Plan of Correction isprepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as ourcredible allegation of compliance.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000225 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 18, 2014, by Janelyn Kulik, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in</p>			

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	<p>progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review, and interview, the facility failed to ensure an allegation of resident to resident altercation was reported to the State Agency for 1 of 3 abuse allegations reviewed. (Resident # 25 and #31)</p> <p>Findings include:</p> <p>During Stage 1 interview with Resident #25 on 7/7/14 at 12:55 p.m., indicated Resident #31 threatened to harm her and the servers in the dining room witnessed the altercation.</p> <p>On 7/8/14 at 3:00 p.m., a review of the facility's records of the mood and behavior communication memos from both witnesses/CNA's dated 5/26/14. CNA #1 and CNA #2's mood and behavior communication memo were dated on 5/26/14 at 12:30 p.m. documented the altercation between Resident #25 and #31.</p>	F000225	<p>There were no negative outcomes for this alleged deficient practice. The abuse allegation for Resident #25 and #31 has been reported to the State Agency. All residents have the potential to be affected. Clinical records have been reviewed and interviews completed for the residents. If a concern was noted regarding an abuse allegation, it was reported to the State Agency. The facility's policy for Reporting Unusual Occurrences has been reviewed with no changes indicated at this time. The Administrator and nursing staff have been re-educated on this policy with a special focus on timely State Agency notification. An Abuse Monitoring form has been implemented. The Administrator or designee will be responsible to review behavior memos and complete the Abuse Monitoring form to ensure the identification and reporting of alleged abuse is being completed in a timely manner. These reviews will occur as</p>	08/10/2014			

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	<p>A letter from the Administrator to the Social Services director dated June 18, 2014 indicated the altercation on 5/26/14 between the two residents and for Social Services to follow up with Resident #25.</p> <p>An interview with the Social Services Director on 7/8/14 at 3:34 p.m., indicated the documentation on the altercation that occurred on 5/26/14 was a late entry on a progress note dated 6/24/14. She further indicated that Resident #31 tried to move around Resident #25's wheelchair while sitting at a table in the dining room next to Resident #31's table. Resident #31 bumped his walker into her wheelchair, repeatedly without having verbalized to other resident to move. Resident #31 threatened Resident #25 then staff had to intervene and escorted Resident #31 out of the dining room.</p> <p>During an interview with the Administrator on 7/9/14 at 9:04 a.m., indicated she follows the guidelines to report abuse; verbal, mental and physical. She further indicated that it should have been reported to the state agency at the time of the altercation.</p> <p>3.1-28(e)</p>		<p>follows: Daily on scheduled work days on an ongoing basis. Should a concern be found, immediate corrective action shall occur. Results of these reviews and any concerns noted will be reviewed during the facility's quarterly QA meetings and the plan adjusted if indicated if found to be ineffective in ensuring the timely reporting of an allegation of abuse to the State agency.</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review, and interview, the facility failed to follow their Resident Abuse Policy related to an allegation of resident to resident altercation was not immediately reported to the State Agency for 1 of 3 abuse allegations reviewed. (Resident # 25 and #31)</p> <p>Findings include:</p> <p>During Stage 1 interview with Resident #25 on 7/7/14 at 12:55 p.m., indicated Resident #31 threatened to harm her and the servers in the dining room witnessed the altercation.</p> <p>On 7/8/14 at 3:00 p.m., a review of the facility's records of the mood and behavior communication memos from both witnesses/CNA's dated 5/26/14. CNA #1 and CNA #2's mood and behavior communication memo were</p>	F000226	<p>There were no negative outcomes for this alleged deficient practice. The resident to resident abuse allegation for Resident #25 and #31 has been reported to the State Agency. All residents have the potential to be affected. Clinical records have been reviewed and interviews completed for the residents. If a concern was noted regarding an abuse allegation, it was reported to the State Agency. The facility's policy for Abuse has been reviewed with no changes indicated at this time. The Administrator and nursing staff have been re-educated on this policy with a special focus on timely State Agency notification. An Abuse Monitoring form has been implemented. The Administrator or designee will be responsible to review behavior memos and complete the Abuse Monitoring form to ensure the Abuse Policy was followed. These reviews will occur as</p>	08/10/2014

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	<p>dated on 5/26/14 at 12:30 p.m. documented the altercation between Resident #25 and #31.</p> <p>A letter from the Administrator to the Social Services director dated June 18, 2014 indicated the altercation on 5/26/14 between the two residents and for Social Services to follow up with Resident #25.</p> <p>An interview with the Social Services Director on 7/8/14 at 3:34 p.m., indicated the documentation on the altercation that occurred on 5/26/14 was a late entry on a progress note dated 6/24/14. She further indicated that Resident #31 tried to move around Resident #25's wheelchair while sitting at a table in the dining room next to Resident #31's table. Resident #31 bumped his walker into her wheelchair, repeatedly without having verbalized to other resident to move. Resident #31 threatened Resident #25 then staff had to intervene and escorted Resident #31 out of the dining room.</p> <p>The "Abuse" policy was provided by the Administrator on 7/8/14 at 3:15 p.m. and she indicated this policy was current. The abuse policy indicated "This facility shall observe the resident's rights to remain free from verbal,... Verbal Abuse 1. Threatening a resident verbally... Procedure ... 7.) The results of all investigations shall be reported to the</p>		<p>follows: Daily on scheduled work days on an ongoing basis. Should a concern be found, immediate corrective action shall occur. Results of these reviews and any concerns noted will be reviewed during the facility's quarterly QA meetings and the plan adjusted should the current plan be deemed ineffective in ensuring timely reporting of an allegation to the State agency.</p>	

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F000280 SS=D	<p>sate survey and certification agency as well as other related agencies within five (5) working days of the incident and/or reporting of the incident...."</p> <p>During an interview with the Administrator on 7/9/14 at 9:04 a.m., indicated she follows the guidelines to report abuse; verbal, mental and physical. She further indicated that it should have been reported to the state agency at the time of the altercation.</p> <p>3.1-28(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse</p>			

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	<p>with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update and revise care plans related to hypertension, CVA (stroke), adjustment from the hospital, and use of an antidepressant for 1 of 15 records reviewed for care plans. (Resident #24)</p> <p>Findings include:</p> <p>Resident #24's record was reviewed on 7/8/14 at 2:38 p.m. The resident was admitted into the facility on 05/25/13.</p> <p>Nurse's notes dated 03/20/14 at 1:30 p.m., indicated the resident was readmitted to facility on 03/20/14 for gross hematuria (blood in urine) due to catheter trauma.</p> <p>A nurses note indicated the resident's Foley Catheter was changed on 5/7/14 at 3:45 a.m., then at 11:45 a.m. the resident was readmitted into the hospital for bleeding from the penis and returned to the facility on 5/13 at 4:45 p.m.</p>	F000280	<p>Resident #24 did not experience any negative outcomes associated with this alleged deficient practice. Resident #24's care plans have been revised including Hypertension, CVA, Adjustment from the Hospital, and use of an Antidepressant. All other residents have the potential to be affected. The careplans for the residents have been reviewed and revised to reflect current status if indicated. The facility's policy for Care Plan Development has been reviewed and no changes are indicated at this time. The Interdisciplinary Team and nurses have been re-educated on the policy with a special focus on revising the care plans with new orders and condition changes. A Care Plan Review form has been implemented. The DON or designee will be responsible for completing the Care Plan Review form to ensure care plans are being revised to reflect a resident's current status. These reviews will be completed as follows on scheduled work days: Daily on an ongoing basis. Should a concern be found, immediate corrective action</p>	08/10/2014			

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	<p>A nurses noted indicated the resident was again sent back to the hospital on 05/13/14 at 5:45 p.m. due to bloody drainage from his penis and large blood clots in catheter bag. The resident returned from the hospital on 05/17/14 at 11 p.m.</p> <p>The Quarterly MDS (Minimal Data Set) Assessment dated 6/13/14 indicated the resident's diagnoses included but were not limited to: anemia, Neurogenic bladder, hyperlipidema (elevated lipid level), non-Alzheimer's Dementia, Parkinson's Disease, depression, COPD (Chronic Obstructive Pulmonary Disease), chronic pain, Atrial fibrillation, BPH (enlarged prostate), dementia with delusions, late effects CVA, CAD (Coronary Artery Disease) and anxiety.</p> <p>A care plan for Hypertension, last reviewed by the facility on 02/05/14, indicated the interventions included, but was not limited to, Norvasc (medication used to lower blood pressure) as ordered.</p> <p>The July, 2014 Physician's Order Summary (POS) lacked documentation of Norvasc.</p> <p>An interview on 7/10/14 at 3:00 p.m. with the DoN (Director of Nursing), indicated the resident was not currently</p>		<p>shall occur. Results of the reviews and any concerns noted will be reviewed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of monitoring increased or decreased) accordingly.</p>	

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	<p>on Norvasc. The DoN further indicated, the Norvasc should have been yellowed out, the care plan should have been updated, and care plans were done quarterly, as needed and with any significant change.</p> <p>A care plan for CVA last reviewed by the facility on 02/05/14, the interventions included, but were not limit to, Aggrenox (anti platelet medication) as ordered.</p> <p>The July, 2014 POS lacked documentation of Aggrenox.</p> <p>An interview on 7/10/14 at 3:00 p.m., with the DoN indicated that the resident was not currently on Aggrenox. The DoN further indicated the Aggrenox should have been yellowed out, the care plan should have been updated and care plans are done quarterly, as needed and with any significant change.</p> <p>The care plan for "Adjustment to new environment from hospital" was last updated by the facility on 3/20/14. During an interview with DoN on 7/10/14 at 3:00 p.m., she indicated the care plan should have been discontinued.</p> <p>The care plan for antidepressant medication originally dated 2/26/14 and updated on 6/23/14 indicated the resident</p>			

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	<p>requires the use of an antidepressant medication Lexapro.</p> <p>The POS for July, 2014 lacked documentation of Lexapro.</p> <p>An interview with the DoN on 7/10/14 at 3:00 p.m., indicated the resident was not currently on Lexapro. The DoN further indicated the Lexapro should have been yellowed out, care plan should have been updated, this was an over site, because the resident had not been on Lexapro for awhile.</p> <p>Interview with the DoN on 07/10/14 at 3:00 p.m., indicated care plans are done by herself and Social Services Director, quarterly, as needed and with any significant condition.</p> <p>On 7/11/14 at 11:42 a.m. the Nurse Consultant provided the policy "CARE PLAN DEVELOPMENT AND REVIEW PROCEDURE," and indicated the policy was current. The policy indicated, "...Policy...4. Care plans are revised as changes in the resident's condition dicatat [sic]...7. Care plans are reviewed and revised as changes occur. Interdisciplinary team review will occur at least quarterly on all residents. 8. Care plans...significant change, and as needed to maintain an up-to-date, clean and</p>			

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F000282 SS=E	<p>legible form. 9. A yellow highlighter is to be used when discontinuing problems, goals, or interventions...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure Physician's orders and care plans were followed as written related to lack of prior interventions completed before PRN (as necessary) pain medication was administered for 1 of 5 residents reviewed for unnecessary medication of the 5 who met the criteria for unnecessary medication, discolorations were not assessed and monitored for 3 of 4 resident's reviewed for skin (non-pressure</p>	F000282	Residents #2, #15, #13,#27, and #31 did not experience any negative outcome related to the alleged deficient practice. Physician's orders and care plans are being followed related to attempting and documenting interventions prior to giving a PRN pain medication. Skin discolorations are being assessed on a weekly basis and such is documented. Dietary recommendations are being addressed and followed through for the residents including those	08/10/2014

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	<p>related) of the 6 who met the criteria for skin (non-pressure related), dietary recommendations not followed through for 1 of 2 residents reviewed for pressure ulcers of the 2 who met the criteria for pressure ulcers, and dietary recommendations not followed through for 1 of 3 residents reviewed for nutrition of the 3 who met the criteria for nutrition. (Residents #2, #15, #13, #27, #31</p> <p>Findings include:</p> <p>1. An interview with Resident #2 on 07/8/14 at 10:05 a.m., indicated he did not have any discomfort or pain.</p> <p>A record review for Resident #2 was completed on 07/8/14 at 2:51 p.m. The Quarterly Minimum Data Set (MDS) Assessment completed on 05/1/14 indicated Resident #2 was cognitively intact and received scheduled pain medication. The MDS indicated the resident did not receive any PRN (as needed) pain medication during the assessment period. The diagnoses included, but were not limited to, diabetes, hypertension (high blood pressure), and depression.</p> <p>A care plan dated 5/15/14 indicated the resident had the potential for pain. The interventions included, but were not</p>		<p>with pressure areas. All residents have the potential to be affected. Their clinical records have been reviewed and corrective action completed if indicated to address following physician's orders and care plans, attempting and documenting interventions prior to giving pain medications, assessing skin discolorations on a weekly basis and documented, the addressing and following through with dietary recommendations. The facility's policies for pain management, skin management, and dietary recommendations have been reviewed and no changes are indicated at this time. The nurses have been re-educated on these policies with a special focus on attempting and documenting interventions prior to giving pain medications, assessing all skin alterations on a weekly basis, and addressing and following through with dietary recommendations. Forms implemented include: Pain and PRN Monitoring form, Skin Management Monitoring form, and Dietary Recommendations Monitoring form. The DON or designee will be responsible for completing the Skin Management Monitoring form and the Pain and PRN Monitoring form to ensure all areas are addressed, documented, and followed through with. These reviews will be completed on scheduled work</p>				

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	<p>limited to, attempt other interventions such as repositioning and elevating bilateral lower extremities.</p> <p>The June and July 2014 Physician Order Summaries (POS) indicated an order for Norco (pain medication)10-325 milligrams (mg). The order indicated to give 1 tablet every 4 hours as needed.</p> <p>The June and July 2014 Medication Administration Records and PRN Medication Flow Sheets indicated Resident #2 received medication on the following dates and times:</p> <p>6/22/14 at 12:30 p.m., received Norco 6/22/14 at 4:30 p.m., received Norco 6/23/14 at 2:30 a.m., received Norco</p> <p>7/2/14 at 4:00 a.m., received Norco 7/4/14 at 2:45 a.m., received Norco 7/7/14 at 2:00 a.m., received Norco</p> <p>The record lacked documentation of any prior non-pharmacological interventions were attempted before administering the PRN pain medication.</p> <p>A facility policy on Medication Administration Policy and Procedure received on 07/10/14 at 1:45 p.m., from the ADoN (Assistant Director of Nursing) and received as current</p>		<p>days as follows: Daily for two weeks, weekly for six weeks, then monthly thereafter. The DON or designee will be responsible for completing the Dietary Recommendations Monitoring form to ensure recommendations are addressed. These reviews will be completed on scheduled work days as follows: Weekly for eight weeks, then monthly thereafter. Should a concern be found,immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of monitoring increased or decreased) accordingly.</p>		

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	<p>indicated "...Purpose: To administer medications according to the guidelines set forth by the State and Federal regulations..." "...Procedure: 31. Documentation should include non-pharmacological interventions attempted prior to resorting to medication administrations..."</p> <p>An interview with LPN #1 on 07/10/14 at 2:24 p.m., indicated she did not use non-pharmacological interventions before giving PRN pain medications to residents. She further indicated she would start with the lowest dose of pain medication first.</p> <p>An interview with the Director of Nursing (DoN) on 7/10/14 at 2:57 p.m., indicated the nurses were supposed to do non-pharmacological interventions before giving pain medications to the residents.</p> <p>2. A) During an observation on 7/7/14 at 2:10 p.m., Resident #15 was observed to have a dark purple discoloration noted to the back of her left hand. The resident was unable to say how she received the discoloration.</p> <p>An observation on 7/10/14 at 9:40 a.m., Resident #15 was sitting in her wheelchair near the nurse's station. The resident was noted to have a dark purple discoloration to the back of her left hand</p>			

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	<p>that was observed on 7/7/14.</p> <p>Record review for Resident #15 was completed on 7/8/14 at 2:22 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and chronic renal failure.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed on 2/15/14 indicated Resident #15 was cognitively intact. The resident was an extensive 1+ person assist for bed mobility and transfers. The MDS Assessment indicated the resident had a functional limitation in range of motion (ROM) to both her upper and lower limbs.</p> <p>Review of the Weekly Skin Assessments for July 2014 indicated a skin assessment was completed on 7/7/14 and no new skin alterations were noted.</p> <p>Review of the July 2014 Shower Sheets indicated the resident received a shower on 7/1/14, 7/4/14, 7/8/14, and 7/11/14 with no skin alterations noted to left hand.</p> <p>Review of the Skin Monitoring Binder on 7/10/14 at 10:20 a.m., lacked evidence of a non-pressure related skin condition sheet for the left hand discoloration.</p>			

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	<p>Resident #15 had a care plan for pressure ulcer/risk for further development of pressure ulcers. The nursing interventions included to observe skin condition while providing care and notify the charge nurse of any skin problems for further assessment.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 7/10/14 at 2:00 p.m., she indicated resident's receive showers twice a week, CNA's fill out a shower sheet and pass it on to the nurse. The nurse should initiate a skin monitoring sheet and then the sheet comes to me and areas are measured weekly. She further indicated she was not aware of any bruising to Resident #15's left hand.</p> <p>Continued interview with the ADON on 7/10/14 at 2:58 p.m., indicated she could not find documentation of the discoloration to Resident #15's left hand. She further indicated the discoloration should have been noticed by staff.</p> <p>Further interview with the ADON on 7/11/14 at 9:30 a.m., indicated the area to Resident #15's left hand was a dark skin discoloration and not a bruise. She further indicated there was no documentation in the record of the left hand skin discoloration.</p>			

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	<p>B) Review of the May 2014 Medication Administration Record (MAR) indicated the resident received Multivitamin tablet 1 tablet every day and Vitamin C 500 milligrams (mg) once a day.</p> <p>Review of the June 2014 MAR indicated the resident received Multivitamin tablet 1 tablet every day and Vitamin C 500 milligrams (mg) once a day.</p> <p>Review of the July 2014 MAR indicated the resident received Multivitamin tablet 1 tablet every day and Vitamin C 500 milligrams (mg) once a day.</p> <p>Review of the Nutritional Assessment Form, dated 5/9/14, indicated a recommendation to change MVI (multivitamin) to MVI with minerals and clarify Vitamin C to 250 mg bid (twice a day) for better absorption.</p> <p>Review of the Nutritional Progress notes, dated 6/27/14, indicated a recommendation to change MVI to MVI with minerals and Vitamin C to 250 mg bid.</p> <p>Resident #15 had a care plan for pressure ulcer/risk for further development of pressure ulcers. The nursing interventions included refer to dietician</p>			

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	<p>as indicated.</p> <p>During an interview with the Director of Nursing (DON) on 7/11/14 at 2:46 p.m., she indicated the resident was not receiving a multivitamin with minerals and was not receiving Vitamin C 250 mg twice a day. She further indicated the dietary recommendations should have been followed through with.</p> <p>3. The record for Resident #13 was reviewed on 7/11/14 10:00 a.m. The resident's diagnoses included, but were not limited to, hypertension, hypothyroidism, and congestive heart failure.</p> <p>The resident was admitted to the facility on 3/12/14. The resident was sent to the hospital on 6/7/14 and readmitted to the facility on 6/12/14.</p> <p>Review of the Nutritional Progress Notes, dated 4/23/14, indicated a recommendation for mighty shakes bid (twice a day) and to check TSH (thyroid lab test) related to weight loss.</p> <p>Review of the April 2014 MAR lacked documentation the resident received mighty shakes. Review of the lab results lacked evidence a TSH level was obtained in April.</p>			

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	<p>Review of the Nutritional Progress Notes, dated 5/22/14, indicated ..."Will rec [recommend] check TSH level again. Will also rec [recommend] appetite stim [stimulant]..."</p> <p>Review of the May 2014 MAR lacked documentation the resident received any appetite stimulant. Review of the lab results lacked evidence a TSH level was obtained in May.</p> <p>Review of the Nutritional Assessment Form, dated 6/20/14, indicated the resident had a 6.05% weight loss from 6/2/14 to 6/12/14 with hospitalization. The note further indicated a recommendation to add supercereal to breakfast and restart CIB (carnation instant breakfast) tid (three times a day).</p> <p>Review of the June 2014 and July 2014 MARs lacked documentation the resident received supercereal or carnation instant breakfast.</p> <p>Review of the resident's diet card indicated lack of evidence of supercereal, carnation instant breakfast, or mighty shakes.</p> <p>Review of the lab results indicated a TSH level was obtained on 6/20/14.</p>			

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	<p>During an interview with the Director of Nursing (DON) on 7/11/14 at 2:46 p.m., she indicated the TSH level should have been obtained more timely. She further indicated the carnation instant breakfast, supercereal and mighty shakes should have been listed on the dietary slip. She indicated the dietary recommendations should have been followed through with.</p> <p>4. During an observation on 7/7/14 at 2:46 p.m., Resident #27 was observed to have a dark purple discoloration noted to her right forearm. The resident indicated it was "probably from them drawing blood"</p> <p>During an observation on 7/10/14 at 9:45 a.m., Resident #27 was lying in her bed in her room. The resident was noted to have a dark purple discoloration to her right forearm that was observed on 7/7/14. The resident indicated she gets bruises very easily but they don't take very long to go away.</p> <p>During an observation on 7/10/14 at 12:17 p.m., Resident #27 was seated at a table in the main dining room reading a newspaper. The resident was noted to have a dark purple discoloration to her right forearm.</p>						

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	<p>A record review for Resident #27 was completed on 7/9/14 at 8:51 a.m. The resident's diagnoses included, but were not limited to, hypertension, atrial fibrillation, and congestive heart failure.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed on 5/30/14 indicated Resident #27 was cognitively intact. The resident was a limited 1+ person assist for bed mobility and transfers. The resident had received an anticoagulant (blood thinning medication) 7 times in the 7 day assessment period.</p> <p>The July 2014 MAR indicated the resident received Coumadin 2 mg every other day alternating with Coumadin 3 mg</p> <p>Review of the Weekly Skin Assessments for July 2014 indicated a skin assessment was completed on 7/4/14 and no new skin alterations were noted.</p> <p>Review of the July 2014 Shower Sheets indicated the resident received a shower on 7/2/14, 7/5/14, and 7/9/14 with no new skin alterations noted.</p> <p>Review of the Skin Monitoring Binder on 7/10/14 at 10:20 a.m., lacked evidence of a non-pressure related skin condition</p>			

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	<p>sheet for the right forearm discoloration.</p> <p>Resident #27 had a care plan for Coumadin (blood thinning medication) use due to atrial fibrillation, dated 5/29/14. The nursing interventions included " ...Observe for signs and symptoms of adverse reactions: diarrhea, headache, hemorrhage, hepatitis, fever, rash, bruises easily..."</p> <p>During an interview with the ADON on 7/10/14 at 2:58 p.m., she indicated there was no documentation of the discoloration to Resident #27's right forearm. She further indicated the discoloration should have been noticed by staff.</p> <p>A Non-Pressure Related Skin Condition form was completed on 7/11/14 at 9:30 a.m. for the discoloration to the right forearm. The area was purple and measured 1.1 centimeters (cm) x 2 cm x &lt; (less than) 0.1 cm.</p> <p>The resident's record lacked documentation the discoloration to the right forearm had been addressed or assessed until brought to the facility's attention.</p> <p>5. Resident #31 was interviewed in his room at 10:05 a.m. on 7/8/14. At that time, he was observed to have a large</p>			
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	<p>puffy bruised area to his right hand which he indicated "I hit on that big metal bar in the bathroom next to the toilet."</p> <p>Resident #31's record was reviewed on 7/9/14 at 9:50 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, edema, pacemaker, bipolar disorder, vascular dementia.</p> <p>The Physician's Order Summary (POS) dated July 2014 indicated the following orders:</p> <ul style="list-style-type: none"> <li>- Weekly skin assess Thurs 11-7 shift</li> <li>- Xarelto (blood thinning medication) 15 mg (milligrams) 1 po (by mouth) qd (daily) - for history of DVT (blood clots)</li> </ul> <p>A fax to the Physician dated 6/17/14 indicated, "(Resident's name) was noted to have a very large purple bruise to most of his right forearm measuring 30 cm [centimeters] x 11 cm. Also had large raised round area to upper left [sic - right] wrist. He says he didn't fall, but hit it on bar in the bathroom."</p> <p>Review of the unit Skin Binder and Resident #31's medical record indicated a lack of any Non-Pressure Skin Monitoring Sheets for Resident #31's right hand or forearm.</p>			

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	<p>Review of the care plan titled "Risk for Skin Tears an Bruising" included the following interventions:</p> <ul style="list-style-type: none"> <li>- Daily skin inspections by nursing assistants</li> <li>- Head to toe skin assessment by licensed staff weekly &amp; PRN (as needed)</li> </ul> <p>Review of the care plan titled "Anticoagulant [blood thinning medication]" indicated the resident has a potential for: 1) hemorrhage (bleeding) 2) Bruising risk - frequently bruises easily, due to the anticoagulant medication Xarelto which is being used to treat bradycardia, history of DVT, pacemaker, cardiomegaly (enlarged heart). Interventions included:</p> <ul style="list-style-type: none"> <li>- Observe for signs and symptoms of bruising easily</li> <li>- Notify charge nurse of noted problems for further follow up</li> </ul> <p>Interventions for the care plan titled "Pressure Ulcer Risk" included:</p> <ul style="list-style-type: none"> <li>- Head to toe weekly skin assessment at least weekly by a licensed nurse</li> <li>- Staff to observe skin conditions while providing care</li> </ul> <p>Skin monitoring sheets were requested for Resident #31 on 7/8/14 at 3:00 p.m. and provided by the Administrator on 7/9/14 in the morning. Charting</p>			

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	<p>indicated:</p> <p>1) 6/17/14 Right forearm bruise, 30 cm x 11 cm, purple. Healed out 7/4/14</p> <p>2) 6/17/14 Right wrist mass 2 cm. 6/22/14 2 cm. 6/27/14 2 cm, wound bed pus looking. 7/4/14 2 cm, wound bed clear.</p> <p>The DoN (Director of Nursing) was interviewed on 7/9/14 1:50 p.m. regarding the bruise charted on a skin monitoring sheet to Resident #31's right forearm measuring 30 x 11 cm on 6/17/14. She indicated she remembered discussing the site with the nurse consultant. She further indicated her name was on the sheet, but was spelled wrong, so it was not her actual signature and she did not fill the sheet out and does not know who did.</p> <p>During an interview with the Administrator on 7/9/14 at 3:35 p.m. regarding the DoN's incorrect signatures on skin sheets for Resident #31, she indicated the name was the DoN's, but was spelled wrong and was not the DoN's usual signature. She further indicated she would look into the matter and questioned the validity of the measurements as well given the incorrect signature.</p> <p>In a follow up interview with the</p>				

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	<p>Administrator on 7/11/14 at 9:50 a.m., she indicated, after investigating the skin sheets for Resident #31, she believed the correct skin sheets couldn't be found so someone tried to reproduce them and signed the DoN's name, therefore those skin sheets are not to be taken as accurate monitoring for Resident #31.</p> <p>6. A facility policy, titled Skin Management Program, dated 10/2013, and received as current from the ADON, indicated "...Residents who receive assistance with bathing and/or peri care will be observed daily by nursing staff and any observance of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations in skin will be reported to the licensed nurse for further assessment...A resident with a newly identified skin condition will have the appropriate assessment ongoing monitoring form initiated on the basis of the type of skin condition...". The policy further indicated, "A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, readmission and at least weekly thereafter ... Should a pressure or non-pressure related skin condition be identified, the licensed nurse will begin the completion of the appropriate initial assessment/ ongoing monitoring form which is then</p>			

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NAME OF PROVIDER OR SUPPLIER  WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F000309 SS=D	<p>placed in the "Skin Binder." Weekly assessments will continue in an effort to identify NEW areas other than those previously identified and being monitored ... Non-Pressure related skin conditions to be housed in the "Skin Binder" and remain in place until the skin condition is cleared/ healed for at least two weeks, at which time it is moved to the "Assessments" section of the medical record ...."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 3 of 4 residents reviewed for non pressure related skin conditions of the 6 residents who met the criteria for non pressure related skin conditions. (Resident #15, #27, and #31)</p>	F000309	A complete body assessment was completed and documented for Resident #15, #27, and #31. Any noted areas are being assessed and documented on weekly until areas are healed. All residents with skin alterations have the potential to be affected. Complete body assessments have been completed and any skin issues are being assessed and documented on weekly until areas are healed. The facility's policy for skin management has	08/10/2014

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	<p>Findings include:</p> <p>1. During an observation on 7/7/14 at 2:10 p.m., Resident #15 was observed to have a dark purple discoloration noted to the back of her left hand. The resident was unable to say how she received the discoloration.</p> <p>During an observation on 7/10/14 at 9:40 a.m., Resident #15 was sitting in her wheelchair near the nurse's station. The resident was noted to have a dark purple discoloration to the back of her left hand that was observed on 7/7/14.</p> <p>A record review for Resident #15 was completed on 7/8/14 at 2:22 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and chronic renal failure.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed on 2/15/14 indicated Resident #15 was cognitively intact. The resident was an extensive 1+ person assist for bed mobility and transfers. The MDS Assessment indicated the resident had a functional limitation in range of motion (ROM) to both her upper and lower limbs.</p> <p>Review of the Weekly Skin Assessments for July 2014 indicated a skin assessment</p>		<p>been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on the policy with special focus on routinely assessing and documenting on skin alterations until healed. A skin management review form has been implemented. The DON or designee will be responsible for completing the skin management review form to ensure areas are assessed and documented on weekly until healed. These reviews will occur on scheduled work days as follows: daily for two weeks, weekly for six weeks, then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of review increased or decreased) accordingly</p>		

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	<p>was completed on 7/7/14 and no new skin alterations were noted.</p> <p>Review of the July 2014 Shower Sheets indicated the resident received a shower on 7/1/14, 7/4/14, 7/8/14, and 7/11/14 with no skin alterations noted to left hand.</p> <p>Review of the Skin Monitoring Binder on 7/10/14 at 10:20 a.m., lacked evidence of a non-pressure related skin condition sheet for the left hand discoloration.</p> <p>Resident #15 had a care plan for pressure ulcer/risk for further development of pressure ulcers. The nursing interventions included to observe skin condition while providing care and notify the charge nurse of any skin problems for further assessment.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 7/10/14 at 2:00 p.m., she indicated resident's receive showers twice a week, CNA's fill out a shower sheet and pass it on to the nurse. The nurse should initiate a skin monitoring sheet and then the sheet comes to me and areas are measured weekly. She further indicated she was not aware of any bruising to Resident #15's left hand.</p>			

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	<p>Continued interview with the ADON on 7/10/14 at 2:58 p.m., indicated she could not find documentation of the discoloration to Resident #15's left hand. She further indicated the discoloration should have been noticed by staff.</p> <p>Further interview with the ADON on 7/11/14 at 9:30 a.m., indicated the area to Resident #15's left hand was a dark skin discoloration and not a bruise. She further indicated there was no documentation in the record of the left hand skin discoloration.</p> <p>2. During an observation on 7/7/14 at 2:46 p.m., Resident #27 was observed to have a dark purple discoloration noted to her right forearm. The resident indicated it was "probably from them drawing blood"</p> <p>During an observation on 7/10/14 at 9:45 a.m., Resident #27 was lying in her bed in her room. The resident was noted to have a dark purple discoloration to her right forearm that was observed on 7/7/14. The resident indicated she gets bruises very easily but they don't take very long to go away.</p> <p>During an observation on 7/10/14 at 12:17 p.m., Resident #27 was seated at a table in the main dining room reading a</p>				

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	<p>newspaper. The resident was noted to have a dark purple discoloration to her right forearm.</p> <p>A record review for Resident #27 was completed on 7/9/14 at 8:51 a.m. The resident's diagnoses included, but were not limited to, hypertension, atrial fibrillation, and congestive heart failure.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment completed on 5/30/14 indicated Resident #27 was cognitively intact. The resident was a limited 1+ person assist for bed mobility and transfers. The resident had received an anticoagulant (blood thinning medication) 7 times in the 7 day assessment period.</p> <p>The July 2014 MAR indicated the resident received Coumadin (a blood thinner) 2 mg every other day alternating with Coumadin 3 mg</p> <p>Review of the Weekly Skin Assessments for July 2014 indicated a skin assessment was completed on 7/4/14 and no new skin alterations were noted.</p> <p>Review of the July 2014 Shower Sheets indicated the resident received a shower on 7/2/14, 7/5/14, and 7/9/14 with no new skin alterations noted.</p>			

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	<p>Review of the Skin Monitoring Binder on 7/10/14 at 10:20 a.m., lacked evidence of a non-pressure related skin condition sheet for the right forearm discoloration.</p> <p>Resident #27 had a care plan for Coumadin (blood thinning medication) use due to atrial fibrillation. The nursing interventions included " ...Observe for signs and symptoms of adverse reactions: diarrhea, headache, hemorrhage, hepatitis, fever, rash, bruises easily..."</p> <p>During an interview with the ADON on 7/10/14 at 2:58 p.m., she indicated there was no documentation of the discoloration to Resident #27's right forearm. She further indicated the discoloration should have been noticed by staff.</p> <p>A Non-Pressure Related Skin Condition form was completed on 7/11/14 at 9:30 a.m. for the discoloration to the right forearm. The area was purple and measured 1.1 centimeters (cm) x 2 cm x &lt; (less than) 0.1 cm.</p> <p>The resident's record lacked documentation the discoloration to the right forearm had been addressed or assessed until brought to the facility's attention.</p>			

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	<p>Surveyor: Hite, Heather</p> <p>3. Resident #31 was interviewed in his room at 10:05 a.m. on 7/8/14. At that time, he was observed to have a large puffy bruised area to his right hand which he indicated "I hit on that big metal bar in the bathroom next to the toilet."</p> <p>Resident #31's record was reviewed on 7/9/14 at 9:50 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, edema, pacemaker, bipolar disorder, vascular dementia.</p> <p>The Physician's Order Summary (POS) dated July 2014 indicated the following orders:</p> <ul style="list-style-type: none"> <li>- Weekly skin assess Thurs 11-7 shift</li> <li>- Xarelto (blood thinning medication) 15 mg (milligrams) 1 po (by mouth) qd (daily) - for history of DVT (blood clots)</li> </ul> <p>A fax to the Physician dated 6/17/14 indicated, "(Resident's name) to have a very large purple bruise to most of his right forearm measuring 30 cm [centimeters] x 11 cm. Also had large raised round area to upper left [sic - right] wrist. He says he didn't fall, but hit it on bar in the bathroom."</p> <p>Review of the unit Skin Binder and</p>			

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	<p>Resident #31's medical record indicated a lack of any Non-Pressure Skin Monitoring Sheets for Resident #31's right hand or forearm.</p> <p>Review of the care plan titled "Risk for Skin Tears an Bruising" included the following interventions:</p> <ul style="list-style-type: none"> <li>- Daily skin inspections by nursing assistants</li> <li>- Head to toe skin assessment by licensed staff weekly &amp; PRN (as needed)</li> </ul> <p>Review of the care plan titled "Anticoagulant [blood thinning medication]" indicated the resident has a potential for: 1) hemorrhage (bleeding) 2) Bruising risk - frequently bruises easily, due to the anticoagulant medication Xarelto which is being used to treat bradycardia, history of DVT, pacemaker, cardiomegaly (enlarged heart). Interventions included:</p> <ul style="list-style-type: none"> <li>- Observe for signs and symptoms of bruising easily</li> <li>- Notify charge nurse of noted problems for further follow up</li> </ul> <p>Interventions for the care plan titled "Pressure Ulcer Risk" included:</p> <ul style="list-style-type: none"> <li>- Head to toe weekly skin assessment at least weekly by a licensed nurse</li> <li>- Staff to observe skin conditions while providing care</li> </ul>			

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	<p>Skin monitoring sheets were requested for Resident #31 on 7/8/14 at 3:00 p.m. and provided by the Administrator on 7/9/14 in the morning. Charting indicated:</p> <p>1) 6/17/14 Right forearm bruise, 30 cm x 11 cm, purple. Healed out 7/4/14 2) 6/17/14 Right wrist mass 2 cm. 6/22/14 2 cm. 6/27/14 2 cm, wound bed pus looking. 7/4/14 2 cm, wound bed clear.</p> <p>The DoN (Director of Nursing) was interviewed on 7/9/14 1:50 p.m. regarding the bruise charted on a skin monitoring sheet to Resident #31's right forearm measuring 30 x 11 cm on 6/17/14. She indicated she remembered discussing the site with the nurse consultant. She further indicated her name was on the sheet, but was spelled wrong, so it was not her actual signature and she did not fill the sheet out and does not know who did.</p> <p>During an interview with the Administrator on 7/9/14 at 3:35 p.m. regarding the DoN's incorrect signatures on skin sheets for Resident #31, she indicated the name was the DoN's, but was spelled wrong and was not the DoN's usual signature. She further indicated she would look into the matter and</p>			

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	<p>questioned the validity of the measurements as well given the incorrect signature.</p> <p>In a follow up interview with the Administrator on 7/11/14 at 9:50 a.m., she indicated, after investigating the skin sheets for Resident #31, she believed the correct skin sheets couldn't be found so someone tried to reproduce them and signed the DoN's name, therefore those skin sheets are not to be taken as accurate monitoring for Resident #31.</p> <p>4. A facility policy, titled Skin Management Program, dated 10/2013, and received as current from the ADON on 7/10/14, indicated "...Residents who receive assistance with bathing and/or peri care will be observed daily by nursing staff and any observance of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations in skin will be reported to the licensed nurse for further assessment...A resident with a newly identified skin condition will have the appropriate assessment ongoing monitoring form initiated on the basis of the type of skin condition...". The policy further indicated, "A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, readmission and at least weekly thereafter</p>			

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F000325 SS=D	<p>... Should a pressure or non-pressure related skin condition be identified, the licensed nurse will begin the completion of the appropriate initial assessment/ ongoing monitoring form which is then placed in the "Skin Binder." Weekly assessments will continue in an effort to identify NEW areas other than those previously identified and being monitored ... Non-Pressure related skin conditions to be housed in the "Skin Binder" and remain in place until the skin condition is cleared/ healed for at least two weeks, at which time it is moved to the "Assessments" section of the medical record ...."</p> <p>3.1-37(a)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p>	F000325	Resident #13 and #15 are	08/10/2014
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	<p>Based observation, record review and interview, the facility failed to ensure each resident maintained acceptable parameters of nutrition related to following through with dietary recommendations for 1 of 3 residents reviewed for nutrition and 1 of 2 residents reviewed for pressure ulcers of the 2 who met the criteria or pressure ulcers. (Resident #13 and #15)</p> <p>Findings include:</p> <p>1. The record for Resident #13 was reviewed on 7/11/14 10:00 a.m. The resident's diagnoses included, but were not limited to, hypertension, hypothyroidism, and congestive heart failure.</p> <p>The resident was admitted to the facility on 3/12/14. The resident was sent to the hospital on 6/7/14 and readmitted to the facility on 6/12/14.</p> <p>Review of the Nutritional Progress Notes, dated 4/23/14, indicated a recommendation for mighty shakes bid (twice a day) and to check TSH (thyroid lab test) related to weight loss.</p> <p>Review of the April 2014 MAR lacked documentation the resident received mighty shakes. Review of the lab results</p>		<p>currently receiving dietary supplements as ordered by the Physician after reviewing the dietary recommendations. . All residents experiencing weight loss or pressure areas have the potential to be affected. Their clinical records have been reviewed including dietary recommendations and the physician was contacted for needed orders if indicated. The facility's policy for Dietary Recommendations has been reviewed and no changes indicated at this time. The nurses have been re-educated on the policy with a special focus on contacting and following through with dietary recommendations. A Dietary Recommendation Review form has been implemented. The DON or designee will be responsible for completing the Dietary Recommendation Review form on scheduled work days as follows: Weekly for eight weeks then monthly thereafter. Should concerns be noted, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of review increased or decreased) if indicated.</p>				

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	<p>lacked evidence a TSH level was obtained in April.</p> <p>Review of the Nutritional Progress Notes, dated 5/22/14, indicated ..."Will rec [recommend] check TSH level again. Will also rec [recommend] appetite stim [stimulant]..."</p> <p>Review of the May 2014 MAR lacked documentation the resident received any appetite stimulant. Review of the lab results lacked evidence a TSH level was obtained in May.</p> <p>Review of the Nutritional Assessment Form, dated 6/20/14, indicated the resident had a 6.05% weight loss from 6/2/14 to 6/12/14 with hospitalization. The note further indicated a recommendation to add supercereal to breakfast and restart CIB (carnation instant breakfast) tid (three times a day).</p> <p>Review of the June 2014 and July 2014 MARs lacked documentation the resident received supercereal or carnation instant breakfast.</p> <p>On 7/10/14 at 12:25 p.m., Resident #13 was observed seated in her recliner chair in her room eating lunch. The resident indicated she had just received her lunch tray. There was no carnation instant</p>						

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	<p>breakfast or mighty shake observed on the resident's tray.</p> <p>Review of the resident's diet card indicated lack of evidence of supercereal, carnation instant breakfast, or mighty shakes.</p> <p>Review of the lab results indicated a TSH level was obtained on 6/20/14.</p> <p>During an interview with the Director of Nursing (DON) on 7/11/14 at 2:46 p.m., she indicated the TSH level should have been obtained more timely. She further indicated the carnation instant breakfast, supercereal and mighty shakes should have been listed on the dietary slip. She indicated the dietary recommendations should have been followed through with.</p> <p>2. The record for Resident #15 was reviewed on 7/8/14 at 2:22 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and chronic renal failure.</p> <p>Review of the May 2014 Medication Administration Record (MAR) indicated the resident received Multivitamin tablet 1 tablet every day and Vitamin C 500 milligrams (mg) once a day.</p> <p>Review of the June 2014 MAR indicated</p>			

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	<p>the resident received Multivitamin tablet 1 tablet every day and Vitamin C 500 milligrams (mg) once a day.</p> <p>Review of the July 2014 MAR indicated the resident received Multivitamin tablet 1 tablet every day and Vitamin C 500 milligrams (mg) once a day.</p> <p>Review of the Nutritional Assessment Form, dated 5/9/14, indicated a recommendation to change MVI (multivitamin) to MVI with minerals and clarify Vitamin C to 250 mg bid (twice a day) for better absorption.</p> <p>Review of the Nutritional Progress notes, dated 6/27/14, indicated a recommendation to change MVI to MVI with minerals and Vitamin C to 250 mg bid.</p> <p>During an interview with the Director of Nursing (DON) on 7/11/14 at 2:46 p.m., she indicated the resident was not receiving a multivitamin with minerals and was not receiving Vitamin C 250 mg twice a day. She further indicated the dietary recommendations should have been followed through with.</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p>			

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a resident's drug regime remained free of unnecessary medications related to the lack of non-pharmacological interventions used before administering PRN (when necessary) pain medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #2)</p>	F000329	Residents #2 did not experience any negative outcome related to the alleged deficient practice. The medication regimen has been reviewed and resident #2 is currently receiving non-pharmacological interventions prior to receiving a PRN pain medication. All residents have the potential to be affected. The medication	08/10/2014

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	<p>Findings include:</p> <p>1. An interview with Resident #2 on 07/8/14 at 10:05 a.m., indicated he did not have any discomfort or pain.</p> <p>A record review for Resident #2 was completed on 07/8/14 at 2:51 p.m. The Quarterly Minimum Data Set (MDS) Assessment completed on 05/1/14 indicated Resident #2 was cognitively intact and received scheduled pain medication. The MDS indicated the resident did not receive any PRN (as needed) pain medication during the assessment period. The diagnoses included, but were not limited to, diabetes, hypertension (high blood pressure), and depression.</p> <p>A care plan dated 5/15/14 indicated the resident had the potential for pain. The interventions included, but were not limited to, attempt other interventions such as repositioning and elevating bilateral lower extremities.</p> <p>The June and July 2014 Physician Order Summaries (POS) indicated an order for Norco (pain medication)10-325 milligrams (mg). The order indicated to give 1 tablet every 4 hours as needed.</p>		<p>regimen of each resident has been reviewed and all unnecessary medications have been discontinued per the MD. Non-pharmacological interventions are being attempted prior to any resident receiving a PRN pain medication. The facility's policy for Medication Administration has been reviewed and no changes are indicated at this time. The nurses and QMAs have been re-educated on the policy with a special focus on completing non-pharmacological interventions prior to giving a PRN medication. A Pain and PRN Medication monitoring form has been implemented. The DON or designee will be responsible for completing the Pain and PRN Medication monitoring form on scheduled work days as follows: daily for two weeks, weekly for six weeks, then monthly thereafter. Should a concern be noted, immediate corrective action shall occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of monitoring increased or decreased) if indicated.</p>				

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	<p>The June and July 2014 Medication Administration Records and PRN Medication Flow Sheets indicated Resident #2 received medication on the following dates and times:</p> <p>6/22/14 at 12:30 p.m., received Norco 6/22/14 at 4:30 p.m., received Norco 6/23/14 at 2:30 a.m., received Norco</p> <p>7/2/14 at 4:00 a.m., received Norco 7/4/14 at 2:45 a.m., received Norco 7/7/14 at 2:00 a.m., received Norco</p> <p>The record lacked documentation of any prior non-pharmacological interventions were attempted before administering the PRN pain medication.</p> <p>A facility policy on Medication Administration Policy and Procedure received on 07/10/14 at 1:45 p.m., from the ADoN (Assistant Director of Nursing) and received as current indicated "...Purpose: To administer medications according to the guidelines set forth by the State and Federal regulations..." "...Procedure: 31. Documentation should include non-pharmacological interventions attempted prior to resorting to medication administrations..."</p> <p>An interview with LPN #1 on 07/10/14 at</p>			

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F000332 SS=D	<p>2:24 p.m., indicated she did not use non-pharmacological interventions before giving PRN pain medications to residents. She further indicated she would start with the lowest dose of pain medication first.</p> <p>An interview with the Director of Nursing (DON) on 7/10/14 at 2:57 p.m., indicated the nurses were supposed to do non-pharmacological interventions before giving pain medications to the residents.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during 5 medication pass observations. Three errors in medications were observed</p>	F000332	Resident # 31 is receiving Artificial Tears and Cosopt eye drops per physician's orders with a wait time of 5 minutes between the different eye medications. Resident #31 is receiving their medications from the pharmacy,	08/10/2014

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	<p>during 26 opportunities for errors in medication administration. This resulted in a medications error rate of 11.53%. (Residents #31 and #34)</p> <p>Findings include:</p> <p>1. A) During an observation of a morning medication pass on 07/10/14 at 9:17 a.m., with LPN #1, LPN #1 prepared resident Resident #31's medications, which included Artificial Tears, two drops into each eye twice a day and Cosopt (glaucoma) one drop into left eye two times daily. LPN #1 administered the Artificial Tears, then waited two and half minutes and administered the Cosopt to the left eye. During an interview after the administration of the eye drops, LPN #1 indicated she should have waited five minutes in between the different eye drops.</p> <p>B) LPN #1 also indicated during the observation, the resident had an order for Oxybutynin (smooth muscle relaxant) CL ER 10 mg (milligram), which was scheduled for 9 a.m. She indicated she could not administer the medication due to the medication was not available. She indicated she had notified the pharmacy on 07/07/14 due to not having the medication and had not worked on 07/08/14. She indicated it had been four</p>		<p>utilizing the EDK, or utilizing the back-up pharmacy to provide the resident's medications in a timely manner. Resident #34 is receiving their medications per physician's orders with proper wait times if medication is to be given before meals. All residents have the potential to be affected. The residents are receiving their medications with proper wait times if indicated. They are also receiving their medications from the pharmacy, utilizing the EDK, or utilizing the back-up pharmacy to provide the residents' medications in a timely manner. The facility's policies for Medication Administration and Order and Receipt of Drugs from Contract Pharmacy Supplier has been reviewed and no changes are indicated at this time. The nurses and QMAs, including LPN #1, have been re-educated on the policies with a special focus on wait times between eyedrops, obtaining medications from the pharmacy in a timely manner and wait times for medications provided before meals. A Medication Pass Procedure form has been implemented. A Medication Delivery Tracking form has also been implemented. The DON or designee will be responsible for completing the Medication Pass Procedure form on scheduled work days reviewing 3 nurses per day on alternating shifts as follows: Daily for two weeks, weekly for two</p>				

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	<p>days since the resident received the Oxybutynin. She indicated the facility had a back up pharmacy, near the facility.</p> <p>Resident #31's record was reviewed on 07/10/14 at 9:06 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and blindness left eye.</p> <p>The Physician's Recapitulation orders, dated 07/14, indicated an order dated 06/02/14 for Oxybutynin CL ER 10 mg, give one tablet every day.</p> <p>The resident's MAR (Medication Administration Record), dated 07/14, indicated the Oxybutynin for July 7, 8, 9, and 10, 2014 had a circle around the initials (medication not given). The back page of the MAR indicated on 07/07/14 and 07/09/14 the Oxybutinen had not been given, due to not available.</p> <p>During an interview on 07/10/14 at 10:29 a.m., the ADoN indicated the pharmacy should have been called when the medication was not available and medication should have been obtained from the back up pharmacy.</p> <p>An undated facility policy, received from the Nurse Consultant on 07/10/14 at 10:40 a.m., Titled, "Medication</p>		<p>weeks,monthly for two months, then quarterly thereafter. The DON or designee will also be responsible for reviewing the Medication Delivery Tracking form on scheduled work days as follows: Daily on an ongoing basis to ensure medications are delivered in a timely manner. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of monitoring increased or decreased) accordingly if indicated.</p>				

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	<p>Administration Policy and Procedure", indicated, "...Each eye drop will be separated by 3-5 minutes to allow for proper absorption.</p> <p>A professional web site for Cosopt, www.merk.com, indicated, "...If you use other medicines in your eye, wait at least 5 minutes between using COSOPT PF and your other eye medicines..."</p> <p>An undated facility policy, received from the Director of Nursing on 07/10/14 at 11:30 a.m. as current, titled, "Order and Receipt of Drugs from Contract Pharmacy Supplier", indicated, "...Drugs and related products will be ORDERED FROM THE PHARMACY in a manner that allows delivery to the facility on a timely basis...If needed before the next regular delivery, telephone the order to the pharmacy immediately upon receipt. Inform the pharmacist of the need for prompt delivery and state the next scheduled administration time...If a medication must be administered before it can be prepared and delivered...and is not available in the EDK (emergency drug kit), the contract pharmacy will attempt to arrange delivery of at least an initial supply from a local pharmacy supplier...Reorder drugs four (4) days in advance of need...Discrepancies and omissions must be reported promptly to</p>			

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	<p>the issuing pharmacy and the charge nurse/supervisor..."</p> <p>2) During a medication administration observation on 07/10/14 at 10:54 a.m., LPN #1 prepared Resident #34's medication, which was metoclopramide (stomach medication) 5 mg/ 5 cc (cubic centimeters). LPN #1 poured the liquid into a graduated plastic medication cup and stepped back from the cart. The amount in the plastic medication cup was 7.5 cc. LPN #1 then indicated, "that may be a little bit over". LPN #1 then emptied part of the liquid into the sharp's container to decrease the liquid to 5 cc.</p> <p>LPN #1 then entered the resident's room, and flushed the g-tube (feeding tube) with 30 cc of water, then administered the the metoclopramide then flushed the g-tube with another 30 cc of water. LPN #1 then administered the resident's feeding of Nutren 2.0, 250 cc's.</p> <p>Resident #34's record was reviewed on 07/10/14 at 2:00 pm. The resident's diagnoses included, but were not limited to, anorexia and achalasia (affects the ability of the esophagus to move food toward the stomach).</p> <p>The Physician's Recapitulation Orders, dated 07/14, indicated an order, dated</p>						

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	<p>03/17/11 for metoclopramide 5 mg/ 5 cc, give 5 cc per feeding tube daily before meals and bedtime.</p> <p>During an interview on 07/10/14 at 1:53 p.m., LPN #1 indicated the metoclopramide should have been given at least 15 minutes before the resident was given his feeding.</p> <p>A professional resource book located at the Nurses' Desk, Mosby's Nursing Drug Reference 2007, page 666, indicated, "...Administer...1/2-1 hr (hour) before meals for better absorption..."</p> <p>A professional resource, titled, "Nursing 2014 Drug Handbook", page 914, indicated, "...give drug at least 30 minutes before eating and at bedtime..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F000363 SS=F	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review and interview, the facility failed to follow the recipe for a therapeutic pureed diet. This had the potential to affect 9 of 9 residents in the facility who received a puree diet.</p> <p>Findings include:</p> <p>On 7/9/14 between 10:24 a.m. and 10:31 a.m. Cook #1 was observed preparing pureed chicken parmesan from the recipe for the serving size of 10 for lunch.</p> <p>Cook #1 added 1 cup of water to the puree chicken parmesan, in which the recipe did not indicate the use of water.</p> <p>The "Chicken Parmesan" recipe for 10 servings ingredients and instructions were "2 lb 8 oz Chicken Parmesan, 10</p>	F000363	<p>There were no residents affected by this alleged deficient practice. The pureed Parmesan Chicken was discarded and re-made using tomato juice per the recipe. The recipes for the pureed diets have been reviewed and changed if indicated to add extra fluid or thickener based on consistency of the pureed food. All residents receiving a pureed diet have the potential to be affected. The pureed Parmesan Chicken was discarded and re-made using tomato juice per the recipe. The recipes for the pureed diets have been reviewed and changed if indicated to add extra fluid used in the recipe or thickener based on consistency of the pureed food. The facility's pureed recipes have been reviewed and changed if indicated to add extra fluid used in the recipe or thickener based on consistency of</p>	08/10/2014

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	<p>each Bread, 2 cup Tomato Juice 1. Measure 4 oz of chicken Parmesan, 1 Bread slice and 3 T of Tomato Ju [sic] for each pureed serving needed. Using a food processor, blend until blended. Stop and scrape side of bowl; continue to blend until smooth...."</p> <p>During an interview on 7/9/14 at 10:52 a.m. the Regional Director #1 indicated this was the current recipe, and Cook#1 should have used more tomato juice in the recipe. He further indicated the recipe should have indicated that if it looked dry, to add more of the fluid that was in the recipe. "I would have never used water". He also indicated he told the kitchen to discard the current chicken parmesan and to remake it according to the recipe.</p> <p>3.1-20(i)(4)</p>		<p>the pureed food. The dietary staff have been re-educated on the policy and changes. A Dietary Observation form has been implemented. The Dietary Manager or designee will be responsible for monitoring pureed diet preparation on scheduled work days during alternating meals as follows: Daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of monitoring increased or decreased) if indicated.</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review the facility failed to ensure the kitchen's meat slicer, pots and skillets were clean and food in the freezer lacked being closed and dated. This had the potential to affect 44 of the 46 residents who received meals prepared in the kitchen.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an observation in the kitchen on 7/8/14 from 10:44 a.m. through 10:57 a.m., the following was observed: <ul style="list-style-type: none"> <li>a. The meat slicer was observed having a crusty food-like substance on the blade.</li> <li>b. A skillet was observed to have a black substance around the inside perimeter of the pan.</li> </ul> </li> </ol>	F000371	<p>There were no residents negatively affected by this alleged deficient practice. The meat slicer was immediately cleaned. The skillet was discarded. The opened packages of frozen mixed vegetables, chopped beef steak, and dough rolls that were in the walk in freezer have been discarded. All opened food packages are being sealed, dated, and labeled when opened.</p> <p>All residents receiving a prepared meal from the kitchen have the potential to be affected. There were no residents negatively affected by this alleged deficient practice. The meat slicer was immediately cleaned. The skillet was discarded. The opened packages of frozen mixed vegetables, chopped beef steak, and dough rolls that were in the walk infreezer have been discarded. All opened food packages are being sealed, dated, and labeled when opened.</p>	08/10/2014

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	<p>During the observation the DM (Dietary Manager) was interviewed and she indicated the meat slicer should have been cleaned better. It was usually cleaned after each use and the last time it was used was a couple days ago. The black substance failed to be removed during the cleansing of the skillet, we probably should have replaced it.</p> <p>On 7/8/14 at 9:00 a.m., the DM provided the policy "Sanitizing Slicer," and she indicated this document was current. This policy indicated, "...It is necessary to clean and sanitize the slicer after each use...."</p> <p>On 7/8/14 at 9:00 a.m., the DM also provided the policy "Sanitizing Pots, Pans and Small Utensils," and she indicated this document was current. This policy indicated, "...It is necessary to ensure that pots, pans and small utensils are cleaned and sanitized properly...."</p> <p>2. On the initial kitchen tour on 7/7/14 between 8:45 a.m. through 9:02 a.m., the following was observed:</p> <p>a. Inside the walk in freezer, the frozen mixed vegetables, chopped beef steak and dough rolls's plastic packages were open and exposed to the air and lacking dates when the bags were opened. The</p>		<p>The facility's policies for Sanitizing the Slicer and Storage of Leftovers have been reviewed and no changes are indicated at this time. The dietary staff have been re-educated on the policies with a special focus on cleaning equipment after each use, sealing open food packages, and dating/labeling of opened packages of food. A Dietary Observation form has been implemented. The Dietary Manager will be responsible for completing the Dietary Observation form on scheduled work days as follows: Varied meal times daily for two weeks, weekly for two weeks, monthly for two months then quarterly thereafter. Should a problem be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of monitoring increased or decreased) if indicated.</p>		

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F000425	<p>foods were soiled to touch.</p> <p>During the initial tour, the DM was interviewed and she indicated that the packages should not have been opened and exposed to the freezer air and further indicated the unused portions of the bags should have been labeled with an open date.</p> <p>On 7/8/14 the DM at 3:00 p.m. provided the policy "Storage of Leftovers," and indicated this document was current. This policy indicated "...Procedure:...2. Place leftovers in seamless containers with tight-fitting lids. 3. Label and date all containers with a 'Use By' date...."</p> <p>3.1-21(i)(2)</p> <p>483.60(a),(b)</p>				

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SS=D	<p><b>PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</b></p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure medications were obtained for a resident, related to a pill not available to administer to a resident as ordered by the resident's physician, for 1 of 6 residents reviewed for medication administration. (Resident #31)</p> <p>Findings include:</p> <p>During an observation of a morning medication pass on 07/10/14 at 9:17 a.m., LPN #1 prepared and administered Resident #31's medications. LPN #1 indicated during the observation, the</p>	F000425	Resident #31 is receiving medications from the pharmacy, utilizing the EDK, or utilizing the back-up pharmacy to provide the resident 's medications in a timely manner. All residents have the potential to be affected. The residents are receiving medications from the pharmacy, utilizing the EDK, or utilizing the back-up pharmacy to provide the residents medications in a timely manner. The facility's policy for Order and Receipt of Drugs from Contract Pharmacy Supplier has been reviewed and no changes are indicated at this time. The nurses, including LPN #1, has been re-educated on the policy with a special focus on obtaining	08/10/2014

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	<p>resident had an order for Oxybutynin (smooth muscle relaxer) CL ER 10 mg (milligram), which was scheduled for 9 a.m. She indicated she could not administer the medication due to the medication was not available. She indicated she had notified the pharmacy on 07/07/14 due to not having the medication and had not worked on 07/08/14. She indicated it had been four days since the resident received the Oxybutynin. She indicated the facility had a back up pharmacy, near the facility.</p> <p>Resident #31's record was reviewed on 07/10/14 at 9:06 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and blindness left eye.</p> <p>The Physician's Recapitulation orders, dated 07/14, indicated an order dated 06/02/14 for Oxybutynin CL ER 10 mg, give one tablet every day.</p> <p>The resident's MAR (Medication Administration Record), dated 07/14, indicated the Oxybutynin for July 7, 8, 9, and 10, 2014 had a circle around the initials (medication not given). The back page of the MAR indicated on 07/07/14 and 07/09/14 the Oxybutynin had not been given, due to not available.</p>		<p>medications from the pharmacy in a timely manner. A Medication Delivery Tracking form has also been implemented. The DON or designee will also be responsible for reviewing the Medication Delivery Tracking form on scheduled work days as follows: Daily on an ongoing basis to ensure medications are delivered in a timely manner. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (method, and/or frequency of monitoring increased or decreased) accordingly if indicated.</p>		

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	<p>During an interview on 07/10/14 at 10:29 a.m., the ADoN indicated the pharmacy should have been called when the medication was not available and medication should have been obtained from the back up pharmacy.</p> <p>An undated facility policy, received from the Director of Nursing on 07/10/14 at 11:30 a.m. as current, titled, "Order and Receipt of Drugs from Contract Pharmacy Supplier", indicated, "...Drugs and related products will be ORDERED FROM THE PHARMACY in a manner that allows delivery to the facility on a timely basis...If needed before the next regular delivery, telephone the order to the pharmacy immediately upon receipt. Inform the pharmacist of the need for prompt delivery and state the next scheduled administration time...If a medication must be administered before it can be prepared and delivered....and is not available in the EDK (emergency drug kit), the contract pharmacy will attempt to arrange delivery of at least an initial supply from a local pharmacy supplier...Reorder drugs four (4) days in advance of need...Discrepancies and omissions must be reported promptly to the issuing pharmacy and the charge nurse/supervisor..."</p> <p>3.1-25(a)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under</p>			

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	<p>proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review the facility failed to label medications and breathing treatments with an open date after opening and to dispose an expired heart medication on 2 of 4 medication carts and 1 of 2 treatment carts. (Resident #27, #15, #45, #24, #3, #14, #41 and #28)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On C Hallway's medication cart the following was observed on 7/11/14 at 1:26 p.m. with LPN #2: <ol style="list-style-type: none"> <li>a. Resident #27 and Resident #15's breathing treatment Ipratropium Bromide 0.5 mg (Milligrams) and albuterol sulfate 3 mg foil package were open and lacking documentation of an open date.</li> <li>b. Resident #27's breathing treatment albuterol 0.083% foil package was open</li> </ol> </li> </ol>	F000431	<p>Resident #27, #15, #45, #24, #3, #14, #41, and #28 did not experience any negative outcomes related to this alleged deficient practice. Resident #27 and Resident #15's breathing treatment Ipratropium Bromide 0.5 mg(Milligrams) and Resident #27's albuterol sulfate 3 mg have been discarded and new packages obtained and labeled with the date opened. Resident #45's opened bottle of Nitrostat and opened package of Levalbuerol HCL have been discarded and new packages obtained and labeled with the date opened. Resident #10's Nitro (Sublingual nitroglycerin-heartmedication) 0.4 mg, Ipratropium Bromide, and Budesonide have been discarded and new packages obtained and labeled with the date opened. Resident #24's Simvastatin was discarded and a new package obtained. Resident #3's and Resident #14's breathing</p>	08/10/2014

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	<p>and lacking documentation of an open date.</p> <p>During an interview on 7/11/14 at 1:43 p.m. with LPN #2, she indicated there should have been a label documenting the day the foil package was opened.</p> <p>The Ipratropium Bromide 0.5 mg and albuterol sulfate 3 mg box indicated once removed from the foil pouch, the individual vials should be used within one week.</p> <p>During an interview on 07/11/14 at 2:05 p.m. with ADoN (Assistant of Director of Nursing), she indicated there was not a policy on labeling the foil package with an open date for breathing treatments.</p> <p>2. On D Hallway's medication cart the following was observed on 7/11/14 at 2:07 p.m. with LPN #2.</p> <p>a. Resident #45's Nitrostat (Sublingual nitroglycerin-heart medication) 0.4 mg bottle was opened lacking an open date and had expired 6/9/13. Two other bottles of Resident #45's Nitrostat 0.4 mg open bottles lacked documentation of an open date and her breathing treatment Levalbuterol HCL 1.25 mg/3 ml solution foil package lacked documentation of an opened date.</p>		<p>treatment Ipratropium Bromide 0.5 mg and albuterol sulfate 3 mg have been discarded and new packages obtained and labeled with the date opened. Resident #41's Budesonide has been discarded and a new package obtained and labeled with date opened. Resident #28's Bacitracin has been discarded and a new package obtained with a label intact on the tube. All residents have the potential to be affected. The medication &amp; treatment carts and the medication rooms in the facility have been checked. Any expired medications have been discarded and new packages obtained. If a medication requiring a date open label was found not to have one in place was discarded and new packages obtained and dated when opened. Any medications found not to have labels on them have been discarded and new packages obtained with labels in place. The facility's policy for Medication Expiration has been reviewed and revised to include medications stored in foil packages. The medications on this list are to be labeled with the date opened. The facility's policy for Drug Labels has been reviewed and no changes are indicated at this time. The nurses have been educated on the policies with a special focus on labeling medications with the date opened, disposing of expired medications, and labels must be</p>				

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	<p>The Levalbuterol HCL (Hydrogen Chloride) 1.25 mg/3 ml (milliliters) solution box indicated once the foil pouch is opened, the vials should be used within two weeks.</p> <p>During the observation of D Hallway medication cart, the LPN #2 indicated there should have been an opening date on the open on the Nitrostat, they were still in use by the resident and the expired Nitrostat should have been discarded.</p> <p>b. Resident #10's Nitro (Sublingual nitroglycerin-heart medication) 0.4 mg lack documentation of an open date on bottle. The breathing treatments of Ipatropium Bromide 0.5 mg and albuterol sulfate 3 mg and Budesonide 0.5 mg/2 ml foil packages were opened and lacked the documentation of an open date.</p> <p>The Ipatropium Bromide 0.5 mg and albuterol sulfate 3 mg box indicated once removed from the foil pouch, the individual vials should be used within one week.</p> <p>The Budesonide 0.5 mg/2 ml box indicated once the foil envelop is opened, use the vials within 2 weeks.</p> <p>During an interview on 07/11/14 at 2:05</p>		<p>present on tubes. A Medication/Treatment Cart and Medication Room Monitoring form has been implemented. The DON or designee will be responsible for completing the Medication/Treatment Cart and Medication Room Monitoring form to ensure medications are labeled with date open, labels are in place on medications and treatments, and expired medications are disposed of on scheduled work days as follows: Daily for two weeks and then weekly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e., frequency of monitoring increased or decreased) accordingly if indicated.</p>	

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	<p>p.m. with ADoN (Assistant of Director of Nursing), she indicated there was not a policy on labeling the foil package with an open date for breathing treatments.</p> <p>c. Resident #24's medication Simvastatin (cholesterol lowering medication) 20 mg had expired on 09/20/13.</p> <p>d. Resident #3's and Resident #14's breathing treatment Ipratropium Bromide 0.5 mg and albuterol sulfate 3 mg foil package lacked an open date.</p> <p>The Ipratropium Bromide 0.5 mg and albuterol sulfate 3 mg box indicated once removed from the foil pouch, the individual vials should be used within one week.</p> <p>During an interview on 07/11/14 at 2:05 p.m. with ADoN (Assistant of Director of Nursing), she indicated there was not a policy on labeling the foil package with an open date for breathing treatments.</p> <p>e. Resident #41's breathing treatment Budesonide 0.25 mg/2 ml foil package lacked an open date.</p> <p>The Budesonide 0.5 mg/2 ml box indicated once the foil envelop is opened, use the vials within 2 weeks.</p>			

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	<p>During an interview on 07/11/14 at 2:05 p.m. with ADoN (Assistant of Director of Nursing), she indicated there was not a policy on labeling the foil package with an open date for breathing treatments.</p> <p>3. On C Hallway Treatment cart the following was observed on 7/11/14 at 2:53 p.m. :</p> <p>a. Resident #28's Bacitracin ointment lacked a label on the tube.</p> <p>During the observation of the treatment cart, an interview with LPN #2 indicated the Bacitracin ointment was in use for the Resident #28.</p> <p>4. On 7/11/14 at 2:30 p.m. the Administrator provided the policy on "Medication Expiration," and she indicated this policy is current. This policy indicated "...The following will be used to establish expiration ...2. Sublingual nitroglycerin tablets will expire one (1) year from the date of opening.</p> <p>On 7/11/14 at 3:42 p.m., the ADoN provided the policy on "DRUG LABELS," and she indicated this policy is current. The policy indicated "...1. all prescription labels must state:...e. Residents's name f. Specific directions</p>			

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F000465 SS=E	<p>for use. g. Physician's name. h. Date drug is dispensed. i. Names, address, and telephone number of dispensing pharmacy...."</p> <p>3.1-25(j) 3.1-25(k) 3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred</p>	F000465	1 and 2. There were no residents negatively affected by this alleged deficient practice but all residents have the potential to be affected.	08/10/2014

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	<p>walls, gouged doors, chipped paint, brown staining on ceiling, and rusted vents throughout the facility. (A,B,C and D halls and Main Dining Room). This had the potential to affect 31 residents residing in the facility and residents who ate in the Main Dining Room.</p> <p>Findings include:</p> <p>1. A Hall</p> <p>a. During an observation of Room 3A on 07/07/14 at 12:27 p.m., the electrical outlet next to the bathroom door had a broken corner.</p> <p>2. B Hall</p> <p>a. During an observation of Room 10 B on 07/8/14 at 10:23 a.m., wires were exposed and hanging from a phone jack under the call light box.</p> <p>b. During an observation of Room 7 B on 07/8/14 at 10:46 a.m., wires were exposed by the call light box.</p> <p>A tour was completed with the Maintenance Director on 07/8/14 at 12:00 p.m., he indicated the areas were in need of repair and was unaware of the areas until they were brought to his attention.</p>		<p>The facility respectfully requests a 30 day extension to allow for all the repairs due to the extensive work that needs to be completed.</p> <p>Items that have been repaired are as follows: A Hall Room 3A has had the electrical outlet next to the bathroom door fixed. Room 1 has had the corner by the closet repainted and is free from chipped paint. The bathroom and room doors have been fixed and are now free from gouges. Room 2 has had the corner by the closet repainted and is free from chipped paint. The bathroom and room doors have been fixed and are now free from gouges and the large hole in the bathroom door. Room 4 has had the closet handle replaced and is no longer broken. The bathroom and room doors have been fixed and are now free from gouges. Room 5 has had the ceiling by the room door repainted and is free from yellow discoloration. The bathroom and room doors have been fixed and are now free from gouges. Room 7 has had the bathroom and room doors fixed and are now free from gouges. Room 8 has had the bathroom and room doors fixed and are now free from gouges. Room 10 has had the bathroom and room doors fixed and are now free from gouges. B Hall Room 10B has had the phone jack fixed and the wires are no longer exposed and hanging. Room 7B has been fixed and the wires are no longer</p>	

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	<p>During the Environmental tour on 07/11/14 at 10:40 a.m., with the Maintenance Director, the following was observed:</p> <p>1. A Hall</p> <p>a. Room 1 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. Two residents resided in this room.</p> <p>b. Room 2 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The outside top of the bathroom door has a large hole. Two residents resided in this room.</p> <p>c. Room 4 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The handle was broken on the closet door. One resident resided in this room.</p> <p>d. Room 5 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was</p>		<p>exposed by the call light box C Hall Room 2 has had the bathroom faucet replaced and is now free from stains D Hall Rooms 2, 3, 7, and 9 have had the bathroom faucet replaced and are now free from stains Items that still need to be repaired and repairs will be completed within 30 days are as follows: A Hall Chipped paint around the closet corners in rooms 4, 5, 7, 8, and 10 Chipped paint around the bathroom sink in room 10 B Hall Gouges in the bathroom doors and room doors in rooms 3, 4, 7, and 10 Chipped paint around the closet corners in rooms 3,4, 7, and 10 Chipped sink in room 4 Caulking behind bathroom sink in room 4 Black mars on walls in room 10 C Hall Gouges in the bathroom doors and room doors in rooms 1, 2, and 7 Chipped paint around the closet corners in rooms 1, 2, and 7 Gouged paint around the soap dispenser in the bathroom of room 1 Chipped paint on windowsill in room 7 D Hall Gouged bathroom doors and room doors in rooms 2, 3, 4, 5, 6, 7, and 9 Chipped paint around the closet corners in rooms 2, 3, 4, 5, 6, 7, and 9 Chipped paint around the shower in room 4 Black mars on the walls in rooms 4 and 9 Black mars on wall in bathroom of rooms 5, 6, and 7 Rusty over-toilet seatbars in room 9 3. The facility's preventative maintenance program has been reviewed and no changes are</p>	

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	<p>chipped paint on the corner of the walls by the closet. The ceiling by the room door had a large yellow discoloration. Two residents resided in this room.</p> <p>e. Room 7 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. Two residents resided in this room.</p> <p>f. Room 8 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. One resident resided in this room.</p> <p>g. Room 10 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. There was paint chipped around the sink in the bathroom. Two residents resided in this room.</p> <p>2. B Hall</p> <p>a. Room 3 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet and window sill. One</p>		<p>indicated at this time. The maintenance director has been re-educated on preventative maintenance with a special focus maintaining a facility in good repair. A Facility Rounds form has been implemented. 4. The Administrator or designee will be responsible for completing the Facility Rounds form on scheduled work days to ensure the facility remains in good repair. Facility rounds will be completed on scheduled work days as follows: Daily for two weeks then weekly thereafter. Should any concerns be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings and the plan adjusted (i.e.increase or decrease in monitoring) if indicated.</p>	

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	<p>resident resided in this room.</p> <p>b. Room 4 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The bathroom sink was chipped on the corner and the caulk was cracked behind the sink. One resident resided in this room.</p> <p>c. Room 7 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. One resident resided in this room.</p> <p>d. Room 10 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. There were black mars on the walls throughout the room. One resident resided in this room.</p> <p>3. C Hall</p> <p>a. Room 1 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The paint was gouged out around the soap dispenser in the</p>			

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	<p>bathroom. Two residents resided in this room.</p> <p>b. Room 2 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The faucet in the bathroom had a white and green substance build up. One resident resided in this room.</p> <p>c. Room 7 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet and window sill. One resident resided in this room.</p> <p>4. D Hall</p> <p>a. Room 2 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The faucet in the bathroom had a green substance build up. One resident resided in this room.</p> <p>b. Room 3 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The faucet in the bathroom had a white substance build up and a</p>			

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	<p>green substance build up to the sink drain. One resident resided in this room.</p> <p>c. Room 4 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet and shower. The room had black mars on walls throughout the room. Two residents resided in this room.</p> <p>d. Room 5 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The bathroom wall had black mars. Two residents resided in this room.</p> <p>e. Room 6 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The bathroom wall had black mars. One resident resided in this room.</p> <p>f. Room 7 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The bathroom walls had black mars. The bathroom faucet handles had a build up of green and white</p>			

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	<p>substances. One resident resided in this room.</p> <p>g. Room 8 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls by the closet. The over the toilet seat bars were rusted in the bathroom. The room had black mars on the walls throughout the room. The bathroom faucet had a white substance build up. One resident resided in this room.</p> <p>h. Room 9 there were gouges out of the bottom inside and outside of the bathroom and room doors. There was chipped paint on the corner of the walls. The faucet handles in the bathroom had a white substance build up. Two residents resided in this room.</p> <p>In an interview with the Maintenance Director during the time of the tour indicated, all above areas were a concern and in need of repair.</p> <p>5. During initial dining observation in the main dining room on 07/07/14 between 11:45 a.m. through 12:22 p.m., the following was observed: a brown staining on the ceiling, the air vents were rusted, the window sills had chipped pain and the walls were marred at chair level.</p>			

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F000520 SS=E	<p>3.1-19(f)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to have an effective QAA (quality assessment and assurance) committee which included a physician and which met at least quarterly throughout the past year. The facility also failed to ensure environmental issues related to gouged, marred, chipped walls and doors throughout all four halls of the facility</p>	F000520	Corrective actions as described in the Plan of Correction were taken relative to environmental issues and unlabeled and expired medications. A facility QA meeting has been scheduled to include a physician and meetings will be held at least quarterly. As all residents could be affected, the following corrective action(s) have been taken. Administrative staff have reviewed the current Quality Assurance Committee	08/10/2014

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	<p>were addressed as well as unlabelled and expired medications in 2 of 4 medication carts and 1 of 2 treatment carts.</p> <p>Findings include:</p> <p>Interview with the Administrator on 7/11/14 at 3:15 p.m., indicated the only QAA meeting conducted in 2014 was on 4/25/14 and the Medical Director (physician representative) was not in attendance or invited. She further indicated that when she started at the facility in March 2014, the former staff indicated there was nothing done or recorded for QAA in 2013. She indicated she was aware of the many environmental issues already, but had not implemented a specific repair plan with target dates of completion. Also indicated no knowledge of issues with medication labeling.</p> <p>1. During the environmental tour on 7/11/14 at 10:40 a.m. with the Maintenance Director, general environmental issues related to gouged, marred, and chipped walls and doors were identified in *** resident rooms on all four halls and in the main dining room. At the time of the tour, the Maintenance Director indicated the areas were in need of repair.</p>		<p>procedures, adding monthly meetings (exceeding the quarterly requirement) to include audits of specific care areas including, but not limited to, environmental issues and unlabeled &amp; expired medications. Administrative nursing shall be responsible to conduct and/or delegate said audits in an effort to identify quality of care areas of concern and address with the QA committee in an effort to formulate an action plan should deficient practice be identified. As a means of quality assurance, the DON and Maintenance Director shall report findings of aforementioned audits and immediate corrective actions taken to the QA committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next Quality Assurance meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified issues.</p>				

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	<p>2. During Medication Storage observation on 7/11/14 at 1:25 p.m., unlabelled and expired medications were found on 2 of 4 medication carts and 1 of 2 treatment carts.</p> <p>A review of the Facility Report titled "Summary of Consultant Pharmacist's Medication Regimen Review" for May 2014, indicated the following issues were identified during carts &amp; med room inspection:</p> <ul style="list-style-type: none"> <li>- Extra "overflow" med cards are in the bottom of the carts , NOT with the "main" med supply. A few med cards were found in the wrong resident med supply.</li> <li>- Not all medications are in date</li> <li>- Medications not dated when opened where required</li> </ul> <p>3.1-52(a)(2) 3.1-52(b)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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